

Department of Mental Health

Guide to New and Current MassHealth Behavioral Health Services



Table of Contents

Section 1

MassHealth: New and Current Services Pg 3

Section 2

Department of Mental Health Protocols Pg 14

Appendix 1

Description of DMH Community Liaison and System Specialist Pg 27

Appendix 2

Community Liaison Directory Pg 30

Section 1

MassHealth: New and Current Services

I.

Section 1

MassHealth: New and Current Services

I. The Children's Behavioral Health Initiative (CBHI)

The Children's Behavioral Health Initiative is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

The Children's Behavioral Health Initiative is defined by a shared commitment to providing services to families that reflect the following values:

- **Family Driven, Child-Centered and Youth Guided**
Services are driven by the needs and preferences of the child and family, developed in partnership with families and accountable to families.
- **Strengths-based**
Services are built on the strengths of the family and their community
- **Culturally Responsive**
Services are responsive to the family's values, beliefs, norms, and to the socio-economic and cultural context.
- **Collaborative and Integrated**
Services are integrated across child-serving agencies and programs.
- **Continuously Improving**
Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence and best practice.

The Initiative places the family and child at the center of our service delivery system, and will build an integrated system of behavioral health services that meets the individual needs of the child and family. The goal is to make it easier for families to find and access appropriate services and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

For more information visit: www.mass.gov/masshealth/childbehavioralhealth

II. MassHealth: New and Current Services

MassHealth pays for many important health care services for a wide range of people who meet the eligibility rules. In 2009, MassHealth significantly expanded behavioral health services available to its MassHealth Standard and CommonHealth members under the age of 21 by paying for six new home and community-based services. The goal of these services is to help children and youth with significant behavioral, emotional and mental health needs achieve success in home, school and community.

These services have been designed, and are being implemented according to Children's Behavioral Health Initiative Values:

- Family Driven, Child-Centered and Youth Guided
- Strengths-based
- Culturally Responsive
- Collaborative and Integrated
- Continuously Improving

These new services *complement* the behavioral health services currently available to MassHealth Standard and CommonHealth members under the age of 21. Below, you will find brief descriptions of the *new* services, and of the *current community-based* MassHealth Behavioral Health Services.

NOTE: These new services are NOT for the treatment of the behavioral health needs of a youth's parents or caregivers. Behavioral Health services for parents or caregivers should be sought through their health care insurer, or MassHealth, if they are eligible.

New MassHealth Community-Based Behavioral Health Services¹

What follows are brief descriptions of the new services, with some suggestions of who might benefit from each of the new services.

This information is intended to provide staff with guidance on how to help families and youth to access appropriate MassHealth behavioral health services. It is important to note that MassHealth members may also self-refer to any behavioral health service they think might be helpful. Families and youth are always welcome to inquire with a provider about a particular service.

This guidance is intended to be informative and to illustrate the potential usefulness of each service. It does NOT replace the Medical Necessity Criteria, attached in Appendix B. Providers of each of the services will use the Medical Necessity Criteria (MNC) to evaluate whether the child or youth has a medical need for the service. Medical Necessity decisions made by providers may be reviewed by the child's or youth's MassHealth Managed Care Plan.

¹ These new services are expected to become available between June 30 and November 1, 2009. However, MassHealth needs the approval of the federal Medicaid program in order to pay for these services. MassHealth has received approval for Intensive Care Coordination and it awaiting approval for the other services.

A. Standardized Behavioral Health Screening in Primary Care

As part of well-child visits, the primary care doctor or nurse checks the child's or youth's health, development, need for immunizations, dental health and behavioral health. MassHealth now requires primary care doctors or nurses to offer to use a behavioral health screening tool to check the child's or youth's behavioral health. There are eight approved screening tools. They typically consist of a short list of questions, or a checklist, that the parent, caregiver or youth fills out and then talks about with the primary care doctor or nurse. The screening tool helps to spot concerns early so problems can be found and helped earlier. If there are concerns about a child's or youth's behavioral health, the primary care doctor or nurse will work with the parent/caregiver or youth to decide if a referral to a behavioral health provider for further assessment and treatment is needed, and can help the parent/caregiver/youth get needed services.

B. Standardized Behavioral Health Assessment, using the Child Adolescent Needs and Strengths tool (CANS)

Beginning November 30, 2008, MassHealth began requiring a uniform behavioral health assessment process for MassHealth members under the age of 21 receiving behavioral health services. The uniform behavioral health assessment process includes a comprehensive needs assessment using the Child and Adolescent Needs and Strengths (CANS) tool.

The CANS is a tool that organizes clinical information collected during a behavioral health assessment in a consistent manner, to improve communication among those involved in planning care for a child or youth. The CANS is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time. The CANS is used in child and youth serving systems in more than 30 states. There are two forms of the Massachusetts CANS: CANS Birth through Four and CANS Five through Twenty. Both versions include questions that enable the assessor to determine whether a child meets the criteria for Serious Emotional Disturbance (SED), in addition to the CANS assessment questions. (Meeting the definition of SED is a component of the Medical Necessity Criteria for the new service Intensive Care Coordination.)

C. Intensive Care Coordination (starting June 30, 2009)

ICC is a care coordination service for children and youth with serious emotional disturbance (For definitions of Serious Emotional Disturbance, see ICC Medical Necessity Criteria, Appendix B). ICC will use a model called *Wraparound Care Planning*. In *Wraparound Care Planning*, families and youth work together with professionals, talk about their strengths and needs, and actively guide their own care. In ICC, a team leader, called a Care Coordinator, helps families bring together a team of people to create a child's treatment plan. This Care Planning Team often includes therapists, teachers, social workers and representatives of all child-serving agencies involved with the youth. It also includes "natural supports", such as family members, friends and people from the family's neighborhood or community that the family invites to be part of the team. Together, the team comes up with ways to support the family's goals for the child (or youth's goals, in the case of an older child), creating an Individual Care Plan. This plan, which also focuses on the family's strengths and respects their cultural preferences, lists all the behavioral health, social, therapeutic or other services needed by the child and family including informal and community

resources. It will guide the youth's care and involve all providers and state agencies to integrate services.

The Care Planning Team will usually meet monthly and sometimes more often for children and youth with more complex needs. At these meetings the family, youth and other team members can talk about progress, work to solve problems, and make any needed changes to the Individual Care Plan.

Additionally the ICC care planning team seeks to:

- Help the family obtain and coordinate services the youth needs and/or receives from providers, state agencies, special education, or a combination thereof
- Assist with access to medically necessary services and ensure these services are provided in a coordinated manner
- Facilitate a collaborative relationship among a youth with SED, his/her family, natural supports, and involved child-serving systems to support the parent/caregiver in meeting their youth's needs

Who is likely to need ICC?

Children and families who need or receive services from multiple providers or who need or receive services from multiple state agencies, including special education. ICC can help prioritize goals and monitor progress, ensuring that interventions being used are effective and coordinated. ICC can also address needs other than behavioral health needs, such as connecting families with a variety of sustainable supports. Examples of sustainable supports include recreational activities for the child or youth, connection to mentors and opportunities for mutual support and social interaction with other families.

Who may benefit from referral to a different service?

- *A child or youth in acute emotional, behavioral or mental health crisis. Consider referring instead to Mobile Crisis Intervention for immediate stabilization and support.*
- *Family of a child or youth with a single service need who does not need a Care Planning Team to coordinate services: Consider referring instead to the service(s) that may be needed.*
- *A family in too much immediate distress to participate in the team-based sequence of steps of the Wraparound process. Consider referring first to another behavioral health service such as Family Stabilization Teams (until November 1, 2009) or In-home Therapy (available November 1 2009, during which the need for other services including ICC will be assessed).*

How do I make a referral?

See the list of Community Service Agencies in Appendix A.

Geographically-Based CSAs: MassHealth's Managed Care Contractors have selected 29 Community Service Agencies (CSAs), one for each of 29 service areas. The service areas correspond to the Areas of the Department of Children and Families.

Culturally and Linguistically Specialized CSAs: MassHealth's Managed Care Contractors have also selected 3 culturally and linguistically specialized CSAs. These CSAs were chosen for their demonstrated ability to reach deeply in to specific cultural or linguistic communities and tailor their services to engage and serve their specified populations. Like all CSAs, Specialized CSAs are expected to serve any family seeking appropriate service without regard to race, ethnicity or language.

- Children's Services of Roxbury specializes in serving the African-American population in Greater Boston.
- The Gandara Center specializes in serving the Latino population in the Springfield/Holyoke area.
- The Learning Center for the Deaf, Walden School specializes in serving the Deaf and Hard of Hearing population, particularly in the eastern/central part of the state.

Families with children or youth enrolled in MassHealth are not required to choose a CSA in their area or a culturally or linguistically specialized CSA, but may choose to work with any CSA.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

D. In-Home Therapy (starting November 1, 2009)

In-Home Therapy Services provides intensive family therapy for a child and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. In-Home Therapy Services are provided in the home or other location which is appropriate and convenient to the family. It is provided by a skilled behavioral health provider who may work in a team with a paraprofessional. In-Home Therapy providers work to understand how the family functions together and how these relationships can be strengthened to benefit the child. Together with the child and family, they create and implement a treatment plan. Goals in a treatment plan might include helping the family identify and use community resources, learn to more effectively set limits and establish helpful routines for their child, problem-solve difficult situations or change family behavior patterns that get in the way of their child's success. Note: Parents may also have individual behavioral health needs that may require separate behavioral health treatment.

Who is likely to need In-Home Therapy?

- *Families in need of more urgent or intensive help with a youth's emotional and behavioral challenges than could be addressed through outpatient therapy.*
- *Families that have identified their primary need as learning new ways to relate to one another, or new ways to set limits or regulate child behavior, or who have tried outpatient therapy but not found it effective.* IHT offers more flexibility than outpatient therapy, not only in intensity but in treatment setting. Therapeutic intervention in a natural environment can offer opportunities for understanding behavior and for rehearsing new strategies which are not available in a clinic environment.

Who may benefit from referral to a different behavioral health service?

- *A child or youth in acute crisis.* Consider referral to Mobile Crisis intervention.

- *Children and families with needs involving multiple providers or state agencies.* Consider referral to ICC.
- *A child with a disorder that can benefit from outpatient individual or family treatment.*

How do I make a referral?

Referrals can be made directly to the In-Home provider or the child may access In-Home therapy through ICC or outpatient therapy.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

For a list of the common network of In-Home providers selected by all MassHealth's Managed Care entities, see Appendix A. For additional providers selected for MBHP's "extended network", also see Appendix A. The most up-to-date information on the In-Home Therapy provider network can also be found on the website of the appropriate MassHealth Managed Care entity or by calling the Managed Care entity.

E. Mobile Crisis Intervention (starting June 30, 2009)

Mobile Crisis Intervention is the youth (under the age of 21) -serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

The service includes: A crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 72 hours of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Who is likely to benefit?

A child with MassHealth who is in a behavioral health crisis and who is likely, without intervention, to escalate in a way that would pose a risk of harm to themselves or others. If in doubt, call the Mobile Crisis Intervention team and consult with the team on whether they should intervene.

Who may benefit from a different service?

If a child is in treatment he or she may have a Risk Management/Safety Plan which may identify other steps prior to calling Mobile Crisis.

Note that Mobile Crisis Intervention is only for a child/youth on MassHealth. A person who does not have MassHealth should be triaged through the 800 number on the back of the health insurance card or sent to the local emergency services program or hospital emergency room.

If the child/youth is an acute safety risk to self or others and the risk cannot be safely managed in the current setting, call 911.

How do I make a referral?

Mobile Crisis Intervention is provided by the Emergency Service Provider (ESP) in the region. See the list of ESPs in Appendix A.

F. Additional new MassHealth-covered services can be accessed through outpatient therapy, In-Home therapy or Intensive Care Coordination, as part of the youth's Individual Care Plan (ICP) or treatment plan (for Outpatient or In-Home Therapy).

➤ *Family Support and Training (Starting June 30, 2009)*

Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community.

Services may include education, assistance in navigating the child serving systems (child welfare, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver.

In ICC, the care coordinator and Family Support and Training Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Support and Training Partner works one-on-one and maintains regular frequent contact the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/ caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The Family Support and Training Partner educates parents/ caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and facilitates the parent's/caregiver's access to these resources. Family Partners are offered to families as part of Intensive Care Coordination.

➤ *In-Home Behavioral Health Services – Starting October 1, 2009*

In-Home Behavioral Health Services offers valuable support to children and youth with challenging behaviors that get in the way of everyday life. Services are provided by a behavioral health provider, such as a therapist, who is skilled in understanding and treating difficult behaviors in children and youth. The provider works closely with the child and family to create a specific behavior plan to improve the child's functioning. The provider may also work as a team with a skilled paraprofessional called a behavioral management monitor. The monitor works with the child and family to implement the child's behavior plan. In-Home Behavioral Health Services can be provided in places where the child is located, including home, school, childcare centers and other community settings.

➤ *Therapeutic Mentoring Services* – Starting October 1, 2009

A therapeutic mentor works one-on-one with a child or youth who, because of their behavioral health needs, require support and coaching to learn social skills that will allow them to do well in typical, normative environments. These skills may include better ways of communicating with other children and adults, dealing with different opinions and getting along with others. The therapeutic mentor works with the child to achieve goals in a treatment plan written by an outpatient therapist, In-Home Therapy Services provider or Intensive Care Coordination (ICC) team. The mentor is supervised by a behavioral health clinician and can work with a child in his or her home, school, or other social and recreational setting.

For families and youth who may need or benefit from these services, social workers should consider facilitating a referral process with the out-patient provider, in-home therapist, or ICC team.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

G. Current MassHealth Community-Based Services (in addition to the New Services)

The following are other community-based (e.g. non-24 hour) behavioral health services that are available to youth enrolled in MassHealth. This is not meant to be an exhaustive list of available benefits but an overview of behavioral health services that are available in addition to the new MassHealth services described earlier in this document.

- **Outpatient Behavioral Health Services:** Outpatient services include individual, family, and group therapies, as well as medication evaluation and monitoring. Outpatient services can be provided in an office, clinic environment, a home, school, or other location. Outpatient services can be used to treat a variety of behavioral health and/or substance abuse issues that significantly interfere with functioning in at least one area of the youth's life (e.g., familial, social, occupational, educational). Outpatient is the least intensive level of care available to youth.
- **Community Support Programs (CSPs):** Provide an array of services delivered by a community-based, mobile, multidisciplinary team of paraprofessionals. CSP services are appropriate for youth who have behavioral health issues challenging their optimal level of functioning in the home/community setting. These services are designed to be maximally flexible in supporting youth who are unable to independently access and sustain

involvement with needed services. Services may include: assisting youth in enhancing their daily living skills; case management, skill building, developing a crisis plan; providing prevention and intervention; and fostering empowerment and recovery, including linkages to peer support and self-help groups. NOTE: As of October 1, 2009, CSP for youth under 18 will be replaced by the new community based behavioral health services, described earlier in this document. Youth 18 through 20 will have access to both CSP services as well as the new community based behavioral health services.

- Structured Outpatient Addiction Program (SOAP): SOAP is a short-term, clinically intensive, structured day and/or evening substance abuse service. SOAP can be used by youth, including pregnant youth, who need outpatient services, but who also need more structured treatment for substance abuse. SOAPs provide multidisciplinary treatment to address the sub-acute needs of youth with addiction and/or co-occurring disorders, while allowing them to maintain participation in the community, continue to work or attend school, and be part of family life.
- Partial Hospitalization Program is a nonresidential treatment program that may or may not be hospital-based. The program provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance abuse evaluation and counseling, and behavioral plans.

How Do I Make a Referral?

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly.

To locate a provider for youth NOT enrolled in a MassHealth Managed Care Plan, please call: MassHealth Customer Service 1-800-841-2900: TTY: 1-800-497-4648.

For youth who ARE enrolled in a MassHealth Managed Care Plan, please call:

- Boston Medical Center (BMC) HealthNet Plan 1-888-566-0010 (English and other languages) 1-888-566-0012 (Spanish) TTY: 1-800-421-1220
- Fallon Community Health Plan 1-800-341-4848 TTY: 1-877-608-7677
- Health New England (HNE) 1-800-786-9999 (TTY: 1-800-439-2370)
- Neighborhood Health Plan 1-800-462-5449 TTY: 1-800-655-1761
- Network Health 1-888-257-1985 TTY: 617-888-391-5535
- Primary Care Clinician (PCC) Plan 1-800-841-2900 TTY: 1-800-497-4648
- Massachusetts Behavioral Health Partnership 1-800-495-0086 TTY: 617-790-4130
- Beacon Health Strategies 1-888-217-3501 TTY: 1-866-727-9441

Section 2

Department of Mental Health Protocols

Strategic Opportunities for the Department of Mental Health

The Children's Behavioral Health Initiative (CBHI) is a collaborative of EOHHS child-serving agencies chaired by the Commissioner of the Department of Mental Health to create an integrated system of care for children's behavioral health in Massachusetts.

The Department of Mental Health (DMH) views the CBHI as a unique opportunity to 1) expand and integrate the array of services for youth with mental health needs and their families in the Commonwealth; 2) develop new approaches to serving these youth and their families; and 3) lay the groundwork for a future seamless delivery system across public and private payers. The protocols described below identify how DMH will interact with the new MassHealth behavioral health services.

CBHI affords DMH the opportunity to expand its role in serving children, youth and families and to build the capacity of the overall system. As the lead voice in policy design, planning and standard setting for serious mental health issues for children, youth, young adults and families, the Department of Mental Health will focus in the coming years on the following strategic priorities:

- Ensure continuity of care for children, adolescents and young adults with serious mental health needs
 1. Promote community tenure for youth with serious mental health problems by providing ongoing services and supports for:
 - Youth with long-term mental health needs who no longer qualify for Intensive Care Coordination or other MassHealth services, but who need one or more services to sustain their tenure in the community, such as case management or flexible community supports.
 - Youth with long-term, significant mental health needs and their families for whom Intensive Care Coordination or other MassHealth services are not a good match but whose needs may be met through a different array of services and supports.
 - Youth and families who are not eligible for MassHealth services and whose needs cannot be met through insurance or other public services.
 2. Provide services and supports to parents and caregivers with serious mental health problems and their children, so that the family unit can remain intact and children can remain in their homes and community
 3. Maintain and expand an infrastructure which provides support to all families and caregivers of children with serious mental health needs, regardless of insurance or DMH status, so that they can more easily manage the strenuous demands of keeping the child at home and in the community.
 4. Continue to provide an array of community services including after school, respite and flexible supports which are not reimbursable by Medicaid or private insurance.

5. Expand community-based partnerships which model best practice for supporting transition-aged youth and young adults with serious mental health issues.
 6. Provide state-of-the-art residential and continuing care inpatient services which link with a community care plan to minimize the duration of out-of-home placement.
 7. Provide leadership in partnering with private health plans in Massachusetts to expand the array of services covered by health insurance
- Serve as a hub for cutting edge research in the field of community-based practice, along with high quality training and peer-learning.
1. Develop and implement a Children's Behavioral Health Research and Training Center which guides the direction and practice of behavioral health intervention and treatment with children and families served by the public and private sectors.
 2. Support the implementation of evidence-based and promising practices in a range of treatment settings.
 3. Utilizing best practices, support interventions across HHS agencies which reduce health care disparities in access and engagement.
 4. Identify workforce needs across disciplines and establish linkages with professional schools and associations re: curriculum development and recruitment strategies.
 5. Measure outcomes of the public children's behavioral health system and assure the design and development of quality management and improvement approaches.
 6. Develop standards for children's behavioral health services across the continuum of care and across state agencies and monitor their implementation.
 7. Implement child and family behavioral health training for EOHHS agencies and Department of Early Education and Care (DEEC).

➤ Community and Systems Consultation, Education and Health Promotion

1. Provide clinical and programmatic consultation to state child serving agencies to improve the identification and treatment of youth with serious mental health issues.
2. Implement Early Identification initiatives which can impact the trajectory of a youth's mental illness.
3. Secure federal and private funding to implement state of the art strategies for prevention and treatment, including public education and awareness campaigns.
4. Partner with Department of Early Education and Care (DEEC) to expand pilots linking preschools with mental health consultation.

DMH Protocols for Accessing and Coordinating with MassHealth Behavioral Health Services

Helping MassHealth-Eligible Youth Access Community-Based Behavioral Health Services

DMH staff will support youth and families access MassHealth behavioral health services in different ways, depending upon their current relationship with DMH:

1. Callers previously unknown to DMH seeking services
 2. Applicants submitting written applications for DMH services
 3. MassHealth-enrolled youth currently receiving DMH services
-
1. For Callers previously unknown to DMH seeking services (including those contacting DMH for services for themselves or individuals calling on their behalf). The DMH staff first determine what information or services the caller is seeking, including whether there is an individual in psychiatric crisis. DMH staff will direct the caller to appropriate resources available through MassHealth, commercial insurance, DMH, and/or community agencies and organizations, including emergency services if necessary.

For MassHealth-enrolled youth:

- If the caller indicates that the youth is experiencing a psychiatric crisis, the caller will be directed to the Emergency Services Program for Mobile Crisis Intervention services, with DMH providing assistance as needed.
- If the youth already has an outpatient clinician or psychiatrist, the DMH staff will share information about the array of MassHealth services as well as DMH services and encourage the caller to have the consenting youth or Legally Authorized Representative (LAR) confer with the youth's outpatient clinician or psychiatrist.
- If the youth does not have a history of receiving behavioral health services, the DMH staff will typically begin by suggesting that the youth or family set up an appointment with an outpatient clinician for a diagnostic behavioral health assessment and a discussion of service options. The DMH staff may also suggest that the youth and family consult with the youth's Primary Care Clinician to ascertain if there are medical conditions causing or contributing to the youth's problem.
- If the youth has a history of significant behavioral health needs or significant trauma, but does not currently have an outpatient clinician or psychiatrist, the DMH staff will share information with the caller about MassHealth behavioral health services that might meet the youth's need for assessment and services. The DMH staff will provide the individual with contact information for the core services, outpatient, In-Home Therapy and Intensive Care Coordination. These services will conduct an assessment and make appropriate referrals. For guidance to DMH staff, Medical Necessity Criteria,

including service descriptions for all new services can be found in Appendix C. Lists of providers for each service by region are included in Appendix A.

- If a youth or LAR knows that s/he is are interested in receiving Intensive Care Coordination or In-Home Therapy services, the consenting youth or family may go directly to a local Community Service Agency for ICC or In-Home Therapy provider to receive a behavioral health assessment and determination of medical need for the service. The DMH staff will assist the youth or LAR in identifying the service providers in their area. (See Appendix A for provider lists.)

For youth with no insurance, or without coverage for the mental health services sought:

- If the youth may be eligible for MassHealth, the caller will be directed to the local MassHealth Customer Service Center at 1-800-841-2900.
- If the caller believes the youth may be disabled and eligible for SSI, the caller will be informed about simultaneously filing an application for SSI. An application for SSI can be initiated through the Social Security Administration's Field offices, or by calling the SSA National Teleservice Line at 1-800-772-1213.

2. For DMH Applicants (individuals submitting written applications for DMH services)

As part of the DMH application process, the DMH Eligibility Determination Specialist contacts the consenting youth or LAR to assess whether current medical entitlements and or insurance are available and sufficient to provide for the needs of the youth for whom services are being sought.

If the youth is enrolled in MassHealth:

- DMH Eligibility Determination Specialist will provide the DMH Applicant with information about those MassHealth services that might meet the youth's need for assessment and or services. Medical Necessity Criteria, including service descriptions for all new services can be found in Appendix C.
- The DMH Eligibility Determination Specialist will provide the applicant with contact information for each of the potentially relevant providers serving the youth's community. A list of providers for each service by region are identified in Appendix A.
- If the youth or LAR intends to seek Intensive Care Coordination services, the Eligibility Determination Specialist will inform the individual that if an ICC Care Planning Team recommends a Child-Adolescent DMH service as an option to meet a goal on the Individual Care Plan, the recommended service may be applied for directly through the DMH liaison assigned to the CSA. Access to such services, either directly through DMH or through the CSA, is subject to DMH's determination that the youth meets DMH's

clinical criteria, the clinical appropriateness of the service, priority and availability, in accordance with DMH service application regulations.

- If the youth or LAR is not interested in participating in MassHealth Intensive Care Coordination, but is interested in receiving DMH services in conjunction with MassHealth behavioral health services, s/he must complete the DMH application process.
- Access to all DMH adult community based services (available at age 18) will require the DMH application.
- All MassHealth enrolled youth and families will be informed about Mobile Crisis services during the application process.

If the youth has MassHealth in addition to private insurance:

- As of July 1, 2009, MassHealth-covered behavioral health services that are medically necessary but that are not covered by the youth's primary health insurer will be provided through MassHealth Behavioral Health Partnership (MBHP). Other MassHealth benefits will continue on a fee-for-service basis. Members affected by this change will receive a letter from MassHealth telling them that they have been enrolled in MBHP, as well as a booklet explaining their behavioral health benefits.
- The process for accessing MassHealth and DMH services for such youth will be the same as above.

If the youth is not insured or has no coverage for mental health services, and if the youth may be eligible for MassHealth:

- DMH will continue the DMH application process, and simultaneously refer the youth or LAR to the local MassHealth Enrollment Center at 1-800-841-2900.
- If the youth might be considered disabled as a result of his/her physical or behavioral health problems, the DMH Eligibility Determination Specialist will advise that the Disability section of the MassHealth application be completed.
- The applicant will also be advised about simultaneously filing an application for SSI. An application for SSI can be initiated through the Social Security Administration's Field offices, or by calling the SSA National Teleservice Line at 1-800-772-1213.

3. MassHealth-Enrolled DMH Clients

- For any DMH-enrolled youth being referred to any MassHealth services, DMH and its providers will seek written authorization to discuss the youth's situation with relevant MassHealth providers and to provide records and participate in joint planning activities as necessary to assist in the transition to MassHealth services.

- If the youth has a DMH Crisis Plan, such plan will include information about what should trigger a call to Mobile Crisis Intervention. If a youth or family calls DMH first, DMH staff can support the youth family in making this call.
- If DMH is contacted concerning a MassHealth-enrolled youth having a behavioral health crisis, the youth, LAR or family will be urged to call the ESP/ Mobile Crisis Intervention service in their area. The DMH staff will have the number of the local ESP/Mobile Crisis Intervention provider available, and will assist in making this call if s/he is requested to do so.
 - If the youth is in a community residential treatment program, the program staff will be directed to contact the ESP/Mobile Crisis Intervention Service directly.
 - If the youth is receiving DMH case management, the DMH case manager will continue to be involved with any youth referred to mobile crisis services, will participate in all crisis planning meetings, may convene an ISP meeting to review the youth's ISP, and will follow up if additional or different support services are needed.
- If the youth is currently receiving DMH case management, the DMH case manager will inform the youth or LAR about Intensive Care Coordination and offer the option to transfer to that service or remain with DMH case management. For such youth who receive MassHealth services other than ICC, the DMH case manager will coordinate these services consistent with the youth's DMH Individual Service Plan (ISP)
- If the youth is living in the community and receives DMH services other than case management, and DMH or program staff responsible for reviewing client progress identify a MassHealth service(s) that can assist the youth to meet his/her goals and objectives, they will inform the youth or LAR about those services
- If the youth is being discharged from DMH residential out-of-home placement, I RTP, or continuing care inpatient services to a community setting:
 - As part of the discharge planning process, DMH staff will seek to ascertain what the youth's MassHealth enrollment status will be subsequent to discharge, and will support the youth or LAR in securing MassHealth coverage for community-based services, such as applying for MassHealth.
 - If the youth will not have coverage in the community, and might be considered disabled as a result of his/her physical or behavioral health problems, the DMH staff will advise that the Disability section of the MassHealth application be completed.
 - The core element of discharge planning from DMH residential or inpatient services involves discussion of the youth's ongoing needs and the options available to meet those needs. As part of the discussion, the DMH case manager assigned to the youth or to the program will share with the youth or LAR the options for care

coordination and other MassHealth behavioral health services in the community. With authorization, the DMH case manager will refer to the behavioral health service selected, and the program will forward requested clinical information and treatment summaries.

- In order to ensure a smooth transition to the community and continuity of clinical care, a referral to ICC may be made up to 180 days, but in any case 90 days, prior to a planned discharge. For youth enrolled in ICC, post-discharge care planning will begin no later than 60 days prior to discharge.
- The DMH-funded inpatient or residential provider is responsible for inviting the ICC to program discharge planning meetings. In addition, they will assist the ICC care coordinator in arranging meetings with the youth, family and/or Care Planning Team at the residential program site. At the time of discharge, the youth and families will be informed about the availability of Mobile Crisis Intervention in the community. DMH will amend its contracts with DMH-funded providers (including continuing care inpatient, IRTP and DMH residential) to clarify expectations regarding this responsibility.
- Mobile Crisis Intervention is not used by CIRT, IRTP or continuing care inpatient programs as they have access to their own clinical staff at all times.

Expected MassHealth Provider Response to Referrals of DMH Clients

For Referrals to Intensive Care Coordination

- Within 24 hours of referral to ICC, the ICC provider will make telephone contact with the youth or LAR to offer a face-to-face interview.
- The ICC provider must offer a face-to-face interview with the youth and/or family within three (3) calendar days of the referral to begin a comprehensive home-based assessment.
- The comprehensive home-based assessment inclusive of the CANS must be completed within 10 calendar days of the date on which consent for ICC was obtained.
- The ICC care coordinator and DMH referral source will be expected to confer to discuss the reason for referral (with proper consent as required by law) as part of the comprehensive home-based assessment process. As part of the comprehensive home-based assessment, the ICC care coordinator is expected to secure youth or LAR authorization and to convey it by fax, mail or hand delivery to DMH and the providers with whom they want to speak.
- The care coordinator will convene the youth's Care Planning Team within 28 calendar days of the youth or LAR's consent to participate in ICC.

For Referrals to In-Home Therapy

- The In-Home Therapy provider responds telephonically to all referrals within one business day.
- During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face meeting with the youth or family seeking services within 24 hours.

General

- If the child or youth does not meet the requirements of the service, or if the youth and family do not wish to participate, the behavioral health provider is expected to provide a referral to other services, as appropriate.

Ensuring Continuity of Care

For youth leaving a DMH out-of-home residential or inpatient program when the youth or LAR has authorized a referral to ICC or In-Home Therapy:

- DMH staff responsible for monitoring utilization of community residential, IRTP, or inpatient programs will ensure that the DMH-contracted provider invites the designated ICC or In-Home Therapy provider to discharge planning meetings and that a minimum of one transition-planning meeting takes place prior to discharge.
- For youth in IRTP or DMH Inpatient programs, the updated CANS completed by the Child/Adolescent residential program clinician will inform the transition to non-residential services. The clinician will provide a printed copy of the CANS to the ICC, In-Home Therapy staff or other MassHealth provider as appropriate. The CANS should be reviewed as part of the discharge planning process.
- DMH-funded residential or inpatient staff responsible for discharge planning will participate in any onsite Care Planning Team meeting (ICC) or treatment planning meeting (for In-Home Therapy) for the purpose of transition to a community setting.
- For youth receiving DMH case management (and not ICC), the DMH case manager will be responsible for coordinating all services, including MassHealth services, identified in the youth's DMH ISP.

For Youth Leaving ICC with a referral to DMH services.

- If ICC and MassHealth community-based services cannot adequately address the youth's needs, (either because the youth has completed ICC service and needs long-term maintenance case management support, or because the youth or LAR determine that ICC is not an appropriate match), the CSA may make a referral to DMH for child adolescent

case management or other services. The DMH liaison will provide the CSA program director with information on the type of documentation needed by DMH to complete the DMH service application process. The DMH liaison will initiate the service authorization process within DMH, and inform the CSA of the outcome of the DMH service application. If the youth is accepted, the liaison will facilitate the transition from ICC to DMH services.

- If the referral is for a youth age 18 or older (MassHealth-enrolled youth may remain enrolled in ICC, or other behavioral health services, until their 21st birthday) the DMH liaison will be contacted by CSA program director who will provide information on the youth's needs. The DMH liaison will brief the DMH adult services staff and assure telephone contact between the youth's care coordinator and the adult specialist within 2 days, to discuss the appropriateness of the referral and needed documentation. If the youth meets the criteria for DMH services, the Liaison will participate in discussion with DMH adult staff and the CSA representative about the most effective way to structure services for the particular youth including assessing the potential roles for the ICC, DMH staff, and the DMH provider.

For a youth in ICC who is admitted to a DMH-funded out-of-home residential or inpatient program.

- If a youth is accepted into DMH-funded residential or inpatient stay is expected to last less than 180 days, the ICC Care Planning Team may continue to meet to plan the youth's transition back to the community. DMH Area staff responsible for residential and inpatient utilization management will invite the ICC care coordinator to participate in pre-admission, service planning, progress review, and discharge planning meetings to facilitate the youth's transition back into the community.
- If a residential or inpatient stay is expected to last more than 180 days, involvement in ICC will end upon the youth's admission. However, prior to admission there will be at least one meeting between appropriate DMH Area and program staff and the ICC Care Planning Team which will include transition and other preadmission planning as well as anticipated issues for discharge planning. If the youth or LAR wishes to receive ICC upon discharge, a new request for ICC services must be made as part of the discharge planning process. If the youth or LAR requests to work with the same Care Coordinator or Family Partner, the Community Service Agency will make reasonable efforts to assign the requested staff. In order to ensure a smooth transition to the community and continuity of clinical care, a referral to ICC may be made up to 180 days, but in any case 90 days, prior to a planned discharge. For youth enrolled in ICC, post-discharge care planning will begin no later than 60 days prior to discharge.

For MassHealth Youth Transitioning from DMH Case Management To ICC:

- DMH case managers will be available to participate in transition activities with proper authorization from the youth or LAR. Activities include but are not limited to: record

sharing; provision of telephone consultation; and attending care planning meetings during the transition period as necessary.

Partnering With Community Service Agencies (CSAs) Providing Intensive Care Coordination (ICC)

Establishing a DMH/CSA Collaborative Relationship:

The Area Directors or designee will establish a working relationship with the director of the Community Service Agency (CSA) in their areas to facilitate collaboration for families served by both agencies. If a Specialized CSA also serves their area, the Area Director or designee will also establish a working relationship with the Specialized CSA. Area Directors or designee are encouraged to meet quarterly with CSA directors.

DMH Liaisons to Each CSA

DMH has designated a DMH liaison to each of the CSAs. This DMH CSA liaison will have several roles including but not limited to:

- Link inquiring families and inquiring providers to the CSA
- Distribute information to pediatric practices, schools and pre-school programs in their designated geographic area about the CSA and other services as requested.
- Educate CSA staff about DMH services, including clinical criteria for different age groups and service specific authorization criteria.
- Authorize access to DMH community resources as available for youth in ICC who meet the DMH service criteria.
- Provide individuals with information about appeals processes for DMH service denials.
- Facilitate the DMH service application process, if appropriate, for youth whose needs cannot be adequately addressed through ICC and MassHealth community-based services and who are seeking either DMH case management or residential services.
- Consult to Care Planning Teams about planning and strategies for assisting families where there is a caretaker with mental illness.
- Provide information to adult caretakers with mental illness about the DMH adult service system and assist in service applications
- Communicate regularly with the DMH appointed designee to the local System of Care Committee.
- Provide assistance to youth and families whose MassHealth entitlement is ending in accessing DMH or other community services

DMH's Role In Individual ICC Care Planning Teams

Because youth are not expected to simultaneously receive DMH case management and Intensive Care Coordination except during the transition from out-of-home placement, DMH staff will not ordinarily serve as ongoing members of individual ICC care planning teams. Rather, working through the CSA program director, the DMH staff liaison will serve as a resource to all Care Planning Teams within the CSA, providing resource linkages and access to DMH services as available and necessary. DMH staff may attend care planning teams during transition to CC or otherwise, upon request and as their time permits. DMH contracted providers delivering services to ICC youth shall participate in the youth's care planning team, with consent of the youth or LAR.

Trainings To Promote Collaboration

- Training of DMH staff: All DMH Site and Area managers and relevant staff will receive training in Wraparound and the details of these protocols,. The purpose of the Wraparound training is to provide an understanding of the process of collaborative care planning and the various roles of DMH staff with respect to this process.
- CSA Training: CSA Directors, Care Coordinators and Family Partners will receive training in the following: DMH clinical criteria for children/adolescent and for adults; the service authorization process including criteria for enrollment in specific services; the array of DMH funded services for children, adolescents, transition age youth and adults; and the roles that DMH and its providers are expected to play for youth and families served through ICC.

DMH Participation In The Local System of Care Committee

The DMH Area Director will designate staff to represent DMH at each of the local System of Care Committees.

When issues arise within a local System of Care Committee of concern to the DMH representative, the representative will bring it back to the DMH Director of Child/Adolescent Services and, as appropriate, to the DMH Site Director, DMH Area Director and/or the DMH representative on the CBHI interagency team at the State level.

Appendix 1

Description of DMH Community Liaison and System Specialist

DMH Community Liaison and Systems Specialist

Each DMH Area will assign a Case Management Supervisor or an Eligibility Determination Specialist to serve as a liaison to each of the 32 Community Service Agencies (CSA) within the Area. CSAs are private agencies contracted by the Medicaid managed care entities to provide Intensive Care Coordination as part of the Rosie D remedy. The key functions assumed by the DMH staff liaison are to serve as a source of information about DMH services and child/adolescent mental health, and to provide interface between the CSA and DMH.

The following are expectations of the Liaison in regard to the CSAs:

1. Introduce him/herself in person to each of the CSA directors and the supervisors of the Intensive Care Coordinators (ICC); explain the role of the DMH Liaison and the structure of DMH services for children/adolescents (C/A), transition age youth (TAY) and adults.
2. Provide or arrange for the CSA and Care Planning Teams(CPT) to receive training and materials on the following
 - DMH clinical criteria for children/adolescents and adults
 - Service array and service authorization criteria for services available to children, adolescents, transition age youth (TAY) , adults and families
 - DMH requirements related to confidentiality and release of information
3. Facilitate access to DMH child/adolescent and adult services as needed
 - The Liaison will be the main point of contact between the CSA and DMH. The CSA director or ICC supervisor (s) will contact the Liaison about any youth or family who the CSA believes to need DMH child/adolescent or adult services.
 - Consultation.
 1. DMH Liaison may consult to the ICC supervisor, and, when necessary and as time permits, to the ICCs and Care Planning Teams about other ways of meeting the youth and family's needs without a referral to DMH.
 2. The Liaison will arrange for consultation from other DMH staff, e.g. adult case manager supervisors, regarding particular issues, such as service planning for families where the caretaker has a mental illness
 3. The Liaison will provide information/consultation about community resource options for youth with SED, how to access such services; and how to work with service providers to mainstream youth with SED.
 - Linkage to DMH services

The CSA director will initiate contact with the Liaison regarding potential referrals to DMH of CSA-involved youth or their family members.

 1. If non- residential Child/Adolescent (C/A) services are being sought to supplement ICC and the MassHealth services, the Liaison will ascertain the availability of the requested service, authorize enrollment if there are vacancies in child/adolescent non-residential programs, or inform CSA when an opening is expected to be available. .
 2. If referral to DMH Child/Adolescent services is being sought because the CSA thinks that ICC and the MassHealth community based services cannot adequately address the youth's needs, the Liaison will inform the CSA of the type of documentation needed by DMH, initiate the service authorization process within DMH, and inform the CSA of the outcome of the DMH service application. If the youth is accepted for DMH service, the liaison will facilitate the transition from ICC to DMH services.

3. If the referral is for a youth age 18 or older, the Liaison will review options available within the DMH Community Based Flexible Support Services contracts, help clarify what is being sought, brief the DMH Area Adult Application Specialist and assure telephone contact between the CSA and the Adult Specialist within 2 days, to discuss the appropriateness of the referral and needed documentation. If the youth meets the criteria for DMH services, the Liaison will participate in discussion with DMH adult staff and the CSA representative about the most effective way to structure services for the particular youth, including assessing the potential roles for the ICC, the DMH provider, and/or DMH case management.
 4. If the referral is for an adult caretaker willing to apply for DMH services, the Liaison will assure telephone contact between the CSA and the Adult Specialist within 2 days. If the caretaker is DCF involved, DMH will offer services for up to 60 days pending a decision about service authorization..
 5. If a youth is losing MassHealth entitlement for any reason, the CSA will discuss the youth and family's ongoing service needs with the Liaison. The Liaison will assist in identifying appropriate resources that can provide care continuity in the community for the youth and family
4. Provide feedback to the CSA regarding the treatment and progress of individuals receiving both ICC and DMH services
 - Given appropriate authorization, the Liaison and the CSA will use a standardized protocol to update each other, on a regular basis, regarding individual progress and salient issues.
 5. Provide information to the public about CSA's
 - The Liaison will distribute materials describing the CSA and MassHealth Services in the course of providing information to the public and to professionals about the range of local mental health services.
 - DMH will provide information about the CSA's to callers and applicants requesting information and will provide them with contact information for the CSA.

Appendix 2

Community Liaison Directory

Department of Mental Health Community Liaison Directory

Organization Name	Service Area	Liaison	Contact Number
The Home for Little Wanderers	Park Street	Mel Stoler	617-626-8975
MSPCC	Dimock Street	Chris Donovan	617-626-8749
The Home for Little Wanderers	Hyde Park	Mel Stoler	617-626-8975
North Suffolk Mental Health Association	Harbor Area	Karen Vaters	617-626-8966
Children's Friend & Family Services	Lawrence	Marianne Vesey	978-738-4539
MSPCC	Lowell	Jim Farren	978-322-5017
Children's Friend & Family Services	Lynn	Sue Kingston	781-477-8212
Health & Education Services	Salem/Cape Ann	Sandy Cormier	978-232-7307
Health & Education Services	Haverhill	Fred Knowles	978-738-4517
Community Counseling of Bristol County, Inc.	Attleboro	Holly Calamese-Grazette	508-897-2056
BAMSI	Brockton	Laura Krim	508-897-2197
Family Services of Greater Fall River	Fall River	Lorna Ketin	508-235-7297
Bay State Community Services	Plymouth	Paul D'Espinosa	508-732-3006
Justice Resource Institute	Cape and Islands	Kristine Monteiro	508-957-0906
Child and Family Services, Inc.	New Bedford	Dawn Nickerson	508-996-7921
Community Healthlink	North Central	Patricia Surette	508-368-3616
Y.O.U. Inc	South Central/Blackstone Valley	Patricia Surette	508-368-3616
Community Healthlink	Worcester East	Rasa Chiras	508-368-3386
Community Healthlink	Worcester West	Rasa Chiras	508-368-3386
Wayside Youth & Family Support Network	Framingham	Meagan Belton	508-616-2197
Bay State Community Services	Coastal	Linda Stanton	617-626-9035
Riverside Community Care	Arlington	Allen Bachrach	781-641-8116
Guidance Center Inc.	Cambridge	Bill Foreman	617-626-8971
Eliot Community Human Services	Malden	Linda Richards	781-224-7915
Clinical & Support Options	Greenfield/Northhampton	Julianne Cole	413-587-6485
Brien Center for Mental Health and Substance Abuse Services	Pittsfield	Kathy Casella	413-395-2007
Carson Center for Human Services Inc.	Holyoke	Denise Hurst	413-493-8009
Behavioral Health Network	Robert Van Wart	Denise Hurst	413-493-8009
Behavioral Health Network	Springfield	Denise Hurst	413-493-8009
Gandara Center - Hispanic	Springfield/Holyoke	Denise Hurst	413-493-8009
Children's Services of Roxbury-African American	Boston	Karen Vaters	617-626-8966
The Learning Center for the Deaf, Walden School- Deaf and Hard of Hearing	Statewide with focus on Metropolitan Boston	TBD- in process	

Email addresses are: First-name.Last-name@Massmail.state.ma.us

